



# KENTUCKY BOARD OF EMERGENCY MEDICAL SERVICES

COMMONWEALTH OF KENTUCKY  
2545 Lawrenceburg Road, Frankfort KY 40601  
Phone: (502) 564-8963 Fax: (502) 564-4687



## APPLICATION TO BECOME A PARAMEDIC STUDENT

Print or Type application:

Educational Institution & Course Number: \_\_\_\_\_

Name: \_\_\_\_\_  
(Last) (First) (Middle) (Maiden Name (if any))

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

Email : \_\_\_\_\_

Telephone: Home (\_\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex (M /F) \_\_\_\_\_

EMT Basic Certification #: \_\_\_\_\_ State of Certification: \_\_\_\_\_

Date of Expiration: \_\_\_\_\_ (Please attach a photocopy of your certification.)

EMS Employment (if applicable):

Employer: \_\_\_\_\_ Type of Business: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Average Hours Worked Per Week: \_\_\_\_\_ Describe your duties: \_\_\_\_\_

**All questions in this section must be answered. Failure to respond to these questions or sign the verification statement will result in this application being returned to you as incomplete.**

1. Do you have a high school diploma or general equivalency diploma?  
(If "Yes", please attach a photocopy.) No \_\_\_\_\_ Yes \_\_\_\_\_
2. Do you have the ability to speak, write, and understand the English language? No \_\_\_\_\_ Yes \_\_\_\_\_
3. Do you currently have a valid motor vehicle operator's license? No \_\_\_\_\_ Yes \_\_\_\_\_
  - State License #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_
4. Have you ever been convicted of a felony, pled guilty to a felony, entered into an alford plea to a felony, or participated in a diversion program for a felony? No \_\_\_\_\_ Yes \_\_\_\_\_
5. Have you ever been convicted of a misdemeanor or DUI? No \_\_\_\_\_ Yes \_\_\_\_\_  
(If yes, please provide a written explanation and a certified copy of court records).
6. Have you ever been cited for a moving violation while operating an emergency medical vehicle?  
(If yes, please provide a written explanation). No \_\_\_\_\_ Yes \_\_\_\_\_
7. Have you ever had a civil judgment entered against you arising from a situation(s) in which you were delivering or attempting to deliver medical care? No \_\_\_\_\_ Yes \_\_\_\_\_
8. Have you ever been in default on any school loans? No \_\_\_\_\_ Yes \_\_\_\_\_  
(If yes, please provide a written explanation).
9. Have you at any time had your certification(s) or registration(s) as an First Responder, EMT or Paramedic or its equivalent, been restricted, revoked, denied, suspended or expired in the Commonwealth of Kentucky or another state? No \_\_\_\_\_ Yes \_\_\_\_\_
10. Do you use drugs, alcohol, or other controlled substances to the extent that it may affect your ability to perform the duties of an EMT? No \_\_\_\_\_ Yes \_\_\_\_\_

**If you answer 'Yes' to any of the above questions, you must attach an explanation on a separate sheet including copies of court documents, disciplinary actions, or physician's statement, if applicable.**



"An Equal Opportunity Employer M/F/H

11. Do you have a physical, mental or other disability for which you are requesting a medical restriction or special accommodation under the Americans With Disabilities ACT (ADA) or a condition that would prevent you from safely performing the duties of a First Responder, EMT or Paramedic? **No** \_\_\_\_\_ **Yes** \_\_\_\_\_
12. If you marked yes on any of the above questions, have you reported this to the KBEMS office in writing? **No** \_\_\_\_\_ **Yes** \_\_\_\_\_

### **AFFIDAVIT OF APPLICANT**

I hereby state that the information contained in this application is true, accurate, and complete to the best of my knowledge and belief. I understand that, under Kentucky Law, the submission of any false, fraudulent or forged statement, document of other matter in connection with this application is grounds for criminal prosecution and denial of certification or licensure. I authorize the Board or its agents to obtain from other sources any information necessary for determining my qualifications for certification or licensure. I also authorize them to furnish any information they may now or in the future have concerning my qualifications and fitness to practice as a paramedic to any person, institution, association, school, hospital or government entity.

\_\_\_\_\_  
*Signature of Applicant*

***If you filled out this section, you must have your signature notarized. If you are out of state, you must have a notary seal.***

State of \_\_\_\_\_ )  
County of \_\_\_\_\_ ) ss

***Subscribed and sworn before me on this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_.***

\_\_\_\_\_  
*Signature of Notary*

*My commission expires:* \_\_\_\_\_

